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The use of dual therapy Quetiapine – psychoanalytic psychotherapy in Hypochondriac Disorder

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Abstract

The specialized literature in the area of psychotherapy posits that hypochondriac disorder has a moderate prognosis, frequent relapses and / or recurrences and a positive response to therapeutic insurances and reinsurances, to treatment, to low dosage of antidepressants and antipsychotic medication. This presentation has a double perspective - a psychotherapeutic one and a medicamentary one of a young patient, with onset of disorder at age 24 and with significant interferences both in the area of psychological vulnerabilities (a history full of significant traumas) as well as in the area of somatic vulnerabilities.

Keywords: depressive disorder; Quetiapine; behavior; therapeutic alliance; antidepressants.

1. Introduction

After five years of treatments, during which the patient received only psychotropic medication, doctors decide to keep her on a single drug, the quick-release form of Quetiapine, coupled with psychological content, within a therapeutic alliance established for the next five years. There are two major hypotheses - that moderate-dose

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antipsychotic enhances the secured climate of psychotherapy and that psychodynamic-oriented psychotherapy is the favorable frame in which Quetiapine may cause “cracks” in the rigid defense of hypochondriac register.

1.1. Debut and history

In 2004, at the age of 25, the patient has a car accident that results in the breakage of the spleen, leading to an emergency surgery (a complete splenectomy), in a small town, at the closest available hospital. Multiple somatic postoperative complications arose after the surgery, ranging from pneumonia, critical weight loss, (approximately 15 kg), asthenia, fatigue and many more. Adjacent to the physical changes felt by the patient after the surgery, the psychological area had some important alterations as well: depression, subjective feeling that life has no meaning and no desire to fight for recovery. Paradoxically, the patient had a sense of gratitude towards the doctors who saved her, but didn’t seem to care whether she would completely recover from the accident or not.

1.2. The first depressive episode:

The first episode of depression begins shortly after the surgery, insomnia being the primary symptom. Corollary, there is a decreased involvement in her relationship with her son, a 4 years-old boy to whom she was very close. In a short period of time, she goes through a variety of mood swings, from depression to irritability, feeling "unhappy", "on the edge", "exhausted", "outraged and condemning the world and life itself". There was an irritable side that manifested itself, centered on existential dissatisfaction, nervousness, inability to do anything, blaming the others for her lack of happiness. This aspect is described by her husband and by the patient herself as "newly emerged" after the accident, but after several years, it actually appears to be just an exacerbation of certain premorbid personality traits from the “para-“ area, such as sensitivity, (non-delusional) interpretability, belief in the "outside-of-things” type of control. Over the next few years since the first meeting with the patient, whom we will call A., the elements of this perpetual state of irritability and depression turned into small, interpretive type of decompensations and an increase in sensitivity. A. never showed clear psychotic decompensation such as delusional ideation or disturbances in the perceptual area.

1.3. The patient presents herself as a case report:

The primary symptom that “accompanied” the patient for more than 10 years was insomnia, which did not disappear, regardless of what antidepressant / antipsychotic she tried. It was concluded that her insomnia was manifesting itself at an ideational level. A. goes to Vienna for an EEG sleep analysis, which confirms some typical changes for chronic insomnia, which emphasizes her psychological belief in an objectification factor of organicity. In Vienna, doctors issued the assumption that a low-dose regimen of treatments should be tried, of which, subjectively, A. seemed pleased about.

2. Patient’s treatment regimen in the beginning

2.1. Treatment followed by A. in the ambulatory system

- June 2004: Coaxil - 3 tablets / day; Xanax - 2 tablets / day
- June – August 2004: there was an increased anxiety, accompanying the main symptom, insomnia.
- Anafranil 25 mg, increased from 1 tablet per week, to up to 3 tablets per day, along with Nitrazepam
- 2005 - Zoloft 50 mg → increased at 200 mg, for 8 months, along with Stilnox - 1 tablet in the evening and another tablet overnight.

Adverse reactions: dizziness and drowsiness, awakening after the first hour of sleep, with restlessness and inability to fall back to sleep. From 2005 until January, 2006: Fevarin - 100 mg (50 mg initially), increased at 150 mg, along with Tranxene 10 mg, 4 tablets / day

2.2. First hospitalization

The patients' first hospitalization takes place in February 2006, at the Psychiatric Hospital "Prof. Dr. Alexandru Obregia" in Bucharest. It lasts for four weeks, during which A. is being kept under surveillance, in the surveillance lounge; she is released on demand, with lack of improvement regarding her mental health status. The only symptoms emerging from her behavior and mental state are: insomnia, depression marked by anhedonia, loss of interest, of pleasure and a concerning decrease in vitality. Having been treated previously by the same doctor in ambulatory regime, her initial treatment as a patient of the hospital began with dual antidepressants, subsequently adding the following combination of medicine: antidepressants, supplemented by antipsychotics, including sleep-inducing sedatives characteristic to classical neuroleptics from the extreme sedative area.

2.3. Treatment followed by A. in the hospital

- Remeron 30 mg / day in combination with Fevarin 100 mg / day,
- Dormicum injections and Orfiril. Her condition aggravated, A. requiring ENP, evolving with anhedonia. She recalls the fact that "I was staying longer in bed." The doctors tried Haloperidol drops and Plegomazin, but "I was in a very confused state", A. continued.

The patient was never psychotic in the strict sense of this term, but raising suspicions that the intensity and persistence of ideation related to the lack of improvement of her condition and her chronic insomnia required antipsychotic approach of these symptoms. Remembering the après-coupe of that admission, A. told her doctors that she has the type of "a special patient" (in the sensitive, not hysterical sense of the term). She added that "I'm scared because I was told I will remain like this throughout my life", "I do not think that supplementing the treatment was a good solution".

3. Patient's treatment regimen of long standing

3.1. First treatment followed by A. outside the hospital

- 2006 (after discharge) → Zyprexa - "I was feeling very ill" - 20 mg / day, with Lexotan 1.5 mg, increased to 3 mg, then increased to 1.5 mg when needed. The patient started thinking the treatment "was addicted. Once every three hours I had high anxiety, cold sweats and tremors. These were not symptoms from my original panel." This treatment lasted for 5 months.
- Subsequently, doctors gave her Remeron, together with Effectin 75 mg in the morning and 75 mg in the evening, and then Effectin was increased to 225 mg for 4 months. "I was feeling very bad from the mix itself. Later, I tried Remeron, didn't help, nor hurt me. The combination was an unhappy one. "

3.2. Second treatment followed by A. outside the hospital

2007 → Trittico 150 mg / day, increased to the maximum dose, even 4 tablets / day. "I slept, for a week, about 4-5 hours per night. I was taking a drug that not only gave me drowsiness, but was actually helping me sleep! I was happy. But after a week, sleeping period was again reduced to no more than two hours." A. says that she tried even taking 6 tablets of Trittico / day (!!) "I could not get out of bed, not even to wash myself. I did not know where the problem was coming from, where did the sickness came from, I felt the pressure of having another hidden mental illness masked by depression. And, as it is with doctors that don't know much about this field, people around me doubted my illness ..."

3.3. Third treatment followed by A. outside the hospital

- "I was in a state where I could not find the strength to get out of bed, couldn't sleep, nor eat"

• Arketis → 20 mg in the morning and 20 mg at noon. It was *"AD that energizes me, as I have been told."* In the evening she was given Lexotan. *"It relaxed me, but I still couldn't get to sleep. I was napping from time to time, but I was in the same situation as before. Not that it is better now, but incomparable ..."*

• *"In Vienna they told me that there is no normal phase of sleep, no sleep trigger mechanism when it comes to my stages of sleep. Basically, the mechanism that helps the body pas through the stages of sleep is missing. They explained that the trigger of this condition was the traumatic shock. For me, the trauma came afterwards, when my physical condition got worse. I lost 15 kg and did not sleep anymore (the accident of 2004). The period after that was very bad, I disconnected from everything I did till then. For one year I had terrible stomach pains that no one could explain. I arrived in Bucharest and went from hospital to hospital. I had high internal bleeding; I rolled on the floor because of the pain. They said that the adhesion was to blame, because for a whole year, the operation did not heal itself."*

3.4. Fourth treatment followed by A. outside the hospital

- Summer 2008 → "From Vienna they didn't give me a treatment, they said I have to begin the therapy. The biggest problem was to manage to get some sleep. In the state I was finding myself, I was unable to go to therapy."
- September 2008 → Doxepin 4 tablets / day, without anxiolytic. Side effects: irritability, intolerance to light and noise, agitation, emotional pain, the feeling of "lump in the throat"
- December 2009 → Mianserin 10 mg, 4tablets / day, together with Rivotril - 2mg
- February 2009 → Cipralex 20 mg / day. Side effects: agitation, anorexia, nausea
- July 2009 → Mianserin 30 mg / day, then increased at 60 mg / day

4. Episode of autoimmune disease

4.1. Onset of autoimmune disease

In the summer of 2009 (the on-set happened in May), A. discovers she has a rash, mainly distributed on the face and neck, accompanied by weight loss, pancytopenia, with modification of antibodies (positive shift of antibodies specific for LES) and symptomatology of atopic dermatitis, urticaria, arthralgia and tendinitis. "I had, on my face, a rash in the shape of butterfly wings, and the same on my neck, joint pains and elevated inflammatory problems." The events are more accentuated in the symptomatic area than in the biological area. A. required corticosteroids (for a period of more than three months, throughout the summer), initially treated with Medrol (injections), and afterwards with Prednisone.

4.2. Beginning of the Seroquel treatment

• July 2009 → "*I had lost all my hair due to the cortisone treatment or due to LES. I had weeks when I wasn't able to eat anything; I was having episodes of agitation and tremors."* **A.** begins treatment with Seroquel IR 12.5 mg - *"I started sleeping 4-5 hours per night. In a few weeks, I got my appetite back, my energy, the mental state was balanced. After four months I was fine. I had taken weight as normal. "*

• At the beginning of 2010 → 100 mg, increased up to 200 mg (due to insomnia and depression) - *"It calms me in a different way than anxiolytics do."*

• 2012→ a long period with 400 mg dosage (200 mg during the day and 200 mg in the evening) - *"It is not something stable. I had some bad times, with worsening of the depression. Whenever I felt better, I would decrease the dosage."*

• *"Seroquel XR had no effect, I was just dazed, it triggered the sensation of sleepiness, I was unable to do anything, couldn't stand upright, but I couldn't go to sleep either. With it, I couldn't sleep, but couldn't do anything else either."*

4.3. The present day

In the evolutionary dynamics of the disorder, during the past 10 years, the patient has undergone a long period of somatic distress (the importance of a life-threatening car accident acting as a trigger for the onset), major depressive episodes (with ongoing psychiatric treatment), an episode of autoimmune, LES-like disease, prevalence of hypochondriac ideation, with behavior alteration, leveling off in the last year under continuous treatment with Quetiapine. Results: establishing a therapeutic alliance in a hybrid frame between psychiatric monitoring and psychological counseling, gaining a full year of unmodified disposition in the sense of depressiveness, without prevalent ideation centered on body functioning, without any manifestations of somatic / autoimmune diseases.

5. Subjective benefits of treatment with Seroquel IR

As we have tried to show during the present paper, the benefits of treatment with Seroquel IR begin with the most important element - inducing sleep. For the patient, it feel as a protective barrier (the psychological defense mechanism), a kind of filter that reduces the intensity of events received, that are coming from outside. Body protection (in terms of psychodynamics) is another valuable benefit. The patient did not present another episode of LES-like disease after the beginning of Seroquel treatment and there was a decrease (in intensity) of symptoms of depression. Significantly, there was a decrease in psychic functioning of the para- extreme - prevalence of the ideation centered on the body-functioning operation. A. had whole months in which the depressive symptoms did not manifest, but the whole social- affective relation of the patient was punctuated by stories related to her symptoms.

6. Unchanged sides of the functioning

• A. couldn't manage to work professionally again (before the car accident, she was a successful business woman in forest transactions, leading a workshop in this regard, with 12 workers). In the professional area, she followed the functions of accuracy, caution, intuitiveness, leading workers and leading her own husband

• Risks the transfer of the emotional ballast of a para- side, investing excessively into an analysis regarding the correctness of the results and performances of her son (it involves major protest actions related to child injustices at interschool competitions)

• Strained relations within the family because of a slight emotional flattening (A. is enclosed in a world of her own, which she blamed on Seroquel, but which she desired and accepted it, in reality)

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